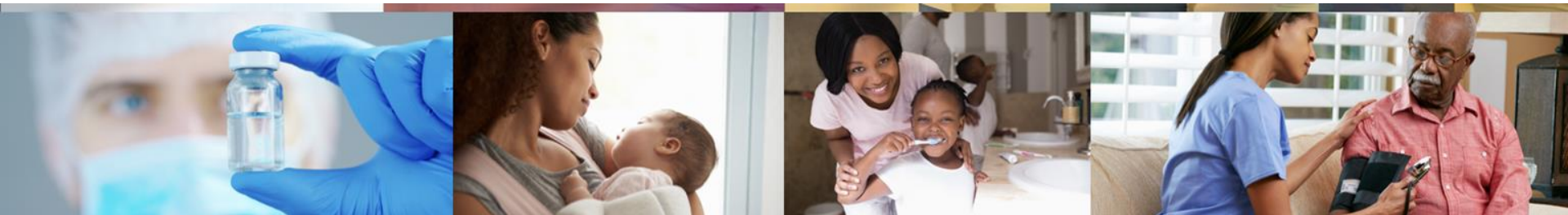
Maryland
DEPARTMENT OF HEALTH

Small Rural Pharmacy Grants Program

Offered by the Office of Pharmacy Services

Thursday, July 9th, 2020 1:00 – 2:00 PM



Welcome & Ground Rules

Deanna Beebe, Program Administrator

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Ground Rules

- Everyone is on mute for the session.
- Please let the Presenters know directly through the Chat if you are having any technical difficulties during the Webinar session.
- Please hold all questions until the end when there will be a Q&A Session.

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Introduction

Overview, Background, & Awards Process

Athos Alexandrou, Director

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Overview & Background

- **Overview –**
  The program is being awarded through MDH's Office of Pharmacy Services to supplement small rural pharmacies in Maryland serving MCO participants in receiving reimbursement not currently covered by appropriated professional dispensing fees and reimbursement rates.

- **Background –**
  The purpose of the Small Rural Pharmacy Grants Program is to support the incorporation of lessons learned from "*Maryland's 2019 Report On The Maryland Medical Assistance Program And Managed Care Organizations That Use Pharmacy Benefits Managers – Audit and Professional Dispensing Fees*" Report.

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Awards Process

- The program will provide grants totaling up to $1,500,000 for small rural pharmacies in the amount of $5.00 per MCO prescription dispensed in the CY 2019.

- This is a noncompetitive funding opportunity.

- Pharmacies must meet a set of eligibility requirements and apply with attachments via email by the submission deadline.

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Applications

Eligibility, Documents, Process, & Timeline

Deanna Beebe

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Eligibility

- Must be a Small Pharmacy (have three [3] stores or less under the same ownership).
- Must be in an area with a rural zip code in Maryland as defined by CMS's "Zip Codes to Carrier Locality" File.
- Must currently be enrolled in the Maryland Medicaid Pharmacy Program and currently providing prescriptions to MCO participants.
- The total # of prescriptions processed by MCOs for the pharmacy must be 30,000 or less for CY 2019.

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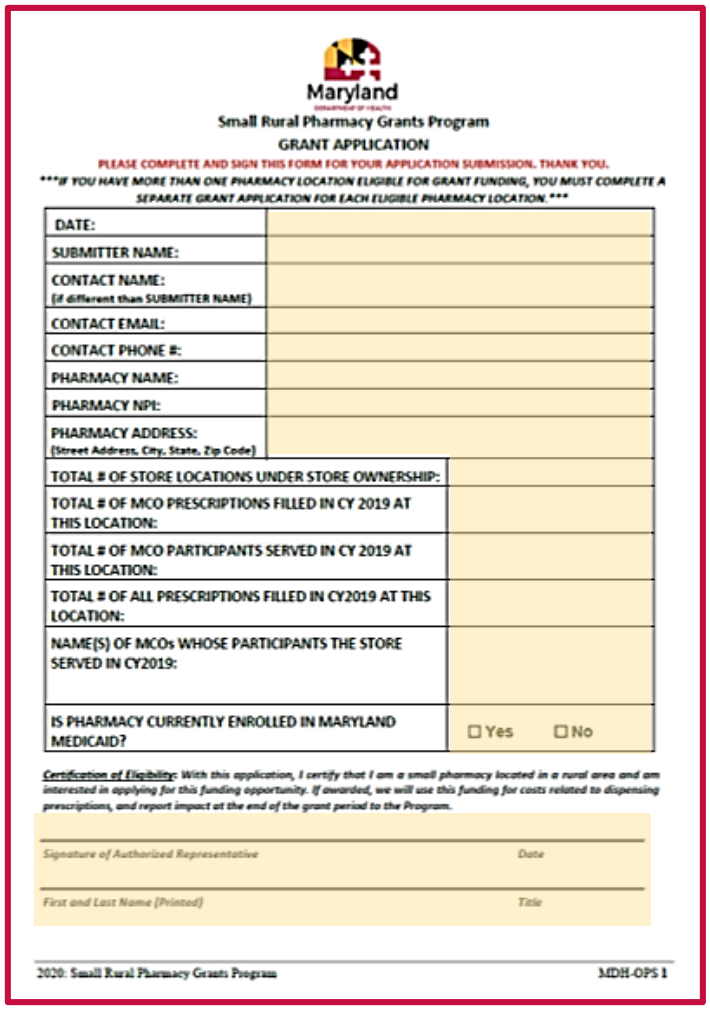
Application Documents

- **Grant Application Form** –
  Must be fully completed with **Certification of Eligibility** signed and dated.

- **W-9 Form** –
  A complete and current IRS W-9 Form must be submitted with the application for the Program to process the pharmacy's information for payment of the grant funds.

Application Documents –
Grant Application Form



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Small Rural Pharmacy Grants Program

GRANT APPLICATION

PLEASE COMPLETE AND SIGN THIS FORM FOR YOUR APPLICATION SUBMISSION. THANK YOU.

IF YOU HAVE MORE THAN ONE PHARMACY LOCATION ELIGIBLE FOR GRANT FUNDING, YOU MUST COMPLETE A SEPARATE GRANT APPLICATION FOR EACH ELIGIBLE PHARMACY LOCATION.

DATE:	
SUBMITTER NAME:	
CONTACT NAME: (if different than SUBMITTER NAME)	
CONTACT EMAIL:	
CONTACT PHONE #:	
PHARMACY NAME:	
PHARMACY NPI:	
PHARMACY ADDRESS: (Street Address, City, State, Zip Code)	
TOTAL # OF STORE LOCATIONS UNDER STORE OWNERSHIP:	
TOTAL # OF MCO PRESCRIPTIONS FILLED IN CY 2019 AT THIS LOCATION:	
TOTAL # OF MCO PARTICIPANTS SERVED IN CY 2019 AT THIS LOCATION:	
TOTAL # OF ALL PRESCRIPTIONS FILLED IN CY2019 AT THIS LOCATION:	
NAME(S) OF MCOs WHOSE PARTICIPANTS THE STORE SERVED IN CY2019:	
IS PHARMACY CURRENTLY ENROLLED IN MARYLAND MEDICAID?	☐ Yes ☐ No

Certification of Eligibility: *With this application, I certify that I am a small pharmacy located in a rural area and am interested in applying for this funding opportunity. If awarded, we will use this funding for costs related to dispensing prescriptions, and report impact at the end of the grant period to the Program.*

Signature of Authorized Representative *Date*

First and Last Name (Printed) *Title*

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DATE:	
SUBMITTER NAME:	
CONTACT NAME: (if different than SUBMITTER NAME)	
CONTACT EMAIL:	
CONTACT PHONE #:	
PHARMACY NAME:	
PHARMACY NPI:	
PHARMACY ADDRESS: (Street Address, City, State, Zip Code)	
TOTAL # OF STORE LOCATIONS UNDER STORE OWNERSHIP:	
TOTAL # OF MCO PRESCRIPTIONS FILLED IN CY 2019 AT THIS LOCATION:	
TOTAL # OF MCO PARTICIPANTS SERVED IN CY 2019 AT THIS LOCATION:	
TOTAL # OF ALL PRESCRIPTIONS FILLED IN CY2019 AT THIS LOCATION:	
NAME(S) OF MCOs WHOSE PARTICIPANTS THE STORE SERVED IN CY2019:	
IS PHARMACY CURRENTLY ENROLLED IN MARYLAND MEDICAID?	☐ Yes ☐ No

Certification of Eligibility: *With this application, I certify that I am a small pharmacy located in a rural area and am interested in applying for this funding opportunity. If awarded, we will use this funding for costs related to dispensing prescriptions, and report impact at the end of the grant period to the Program.*

Signature of Authorized Representative *Date*

First and Last Name (Printed) *Title*

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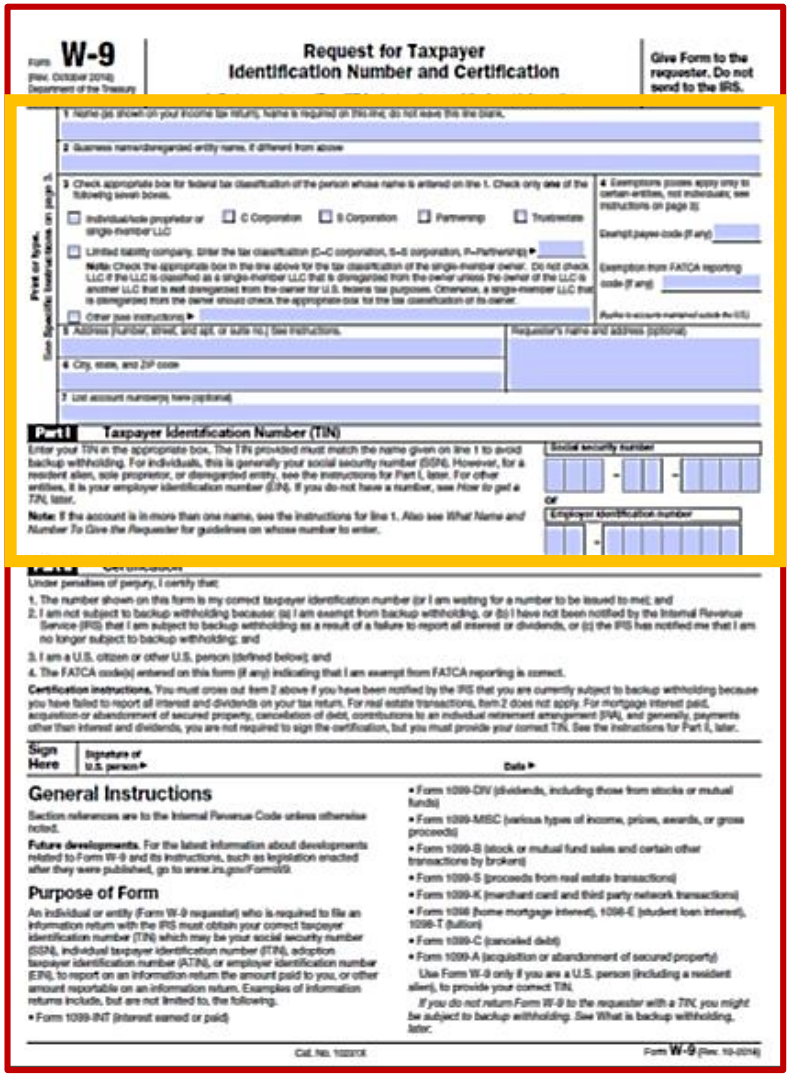
Application Documents – W-9 Form



Form **W-9**
(Rev. October 2018)
Department of the Treasury

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type.
See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):
Exempt payee code (if any)
Exemption from FATCA reporting code (if any)
(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I **Taxpayer Identification Number (TIN)**

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number
___ - ___ - ____
or
Employer identification number
__ - _____

Part II **Certification**

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here Signature of U.S. person ▶ Date ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.

Cat. No. 10231X Form **W-9** (Rev. 10-2018)

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Application Process

- The **Request For Applications** packet contains a paper version of the **Grant Application Form**, which can be filled out and scanned to be sent to the Program. You may also request an electronic version of the document.
- The **W-9 Form** can be found at: https://www.irs.gov/pub/irs-pdf/fw9.pdf.
- Application documents must be submitted via email to **Deanna Beebe** at deanna.beebe@maryland.gov and received by 5:00 PM EST on Friday, July 31st, 2020.
    - If you cannot submit your documents via email, please contact **Deanna Beebe** via email or call at (410) 767-5701 *at least 24hrs before the submission deadline*.

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Awards

Documents & Timeline

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Awards Documents

- **Notification of Award Letter –**
  This letter will be emailed/mailed by Aug. 21st notifying you if you have received a grant award (based on your eligibility and the completeness and timeliness of your application submission).

- **Grant Agreement –**
  This document lists your exact award amount and must be signed and returned to the Program by Aug. 31st for you to receive your grant funding and legally binds you to the terms of the grants program.

- **Statement of Obligations, Assurances, and Conditions –**
  This document must be signed and returned to the Program by Aug. 31st for you to receive your grant funding and legally binds you to the terms of the grants program.

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Awards Documents cont.

- **Invoice for Funding Worksheet –**

  This worksheet must be filled out completely and sent in with the signed **Grant Agreement** and **Statement of Obligations, Assurances, and Conditions** and returned to the Program by Aug. 31st for you to receive your grant funding.

- **Final Report –**

  This document must be filled out completely and returned to the Program after the end of the funding period by 5:00 PM EST on Friday, July 30th, 2021.

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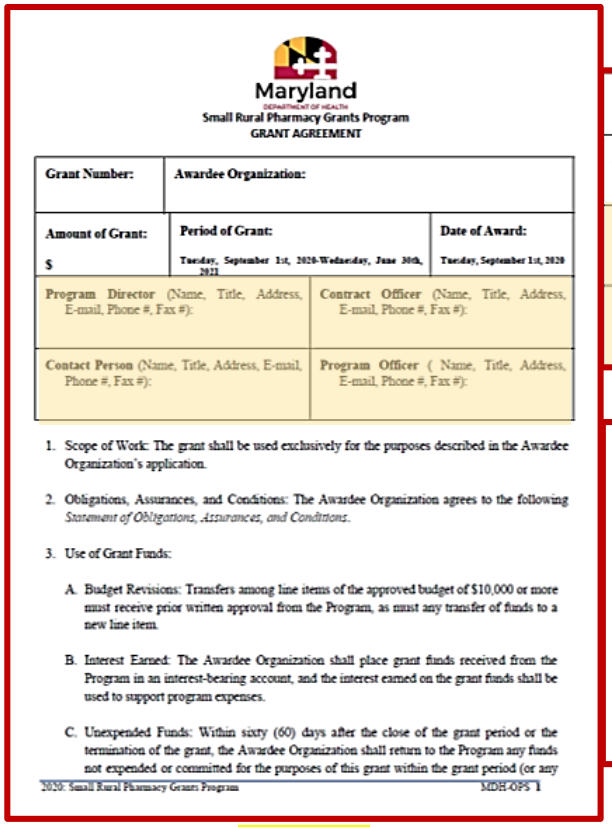
Awards Documents cont. –
Grant Agreement



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Small Rural Pharmacy Grants Program
GRANT AGREEMENT

Grant Number:	Awardee Organization:	
Amount of Grant: $	Period of Grant: Tuesday, September 1st, 2020-Wednesday, June 30th, 2021	Date of Award: Tuesday, September 1st, 2020
Program Director (Name, Title, Address, E-mail, Phone #, Fax #):		Contract Officer (Name, Title, Address, E-mail, Phone #, Fax #):
Contact Person (Name, Title, Address, E-mail, Phone #, Fax #):		Program Officer (Name, Title, Address, E-mail, Phone #, Fax #):

1. Scope of Work: The grant shall be used exclusively for the purposes described in the Awardee Organization's application.
2. Obligations, Assurances, and Conditions: The Awardee Organization agrees to the following *Statement of Obligations, Assurances, and Conditions*.
3. Use of Grant Funds:
   A. Budget Revisions: Transfers among line items of the approved budget of $10,000 or more must receive prior written approval from the Program, as must any transfer of funds to a new line item.
   B. Interest Earned: The Awardee Organization shall place grant funds received from the Program in an interest-bearing account, and the interest earned on the grant funds shall be used to support program expenses.
   C. Unexpended Funds: Within sixty (60) days after the close of the grant period or the termination of the grant, the Awardee Organization shall return to the Program any funds not expended or committed for the purposes of this grant within the grant period (or any

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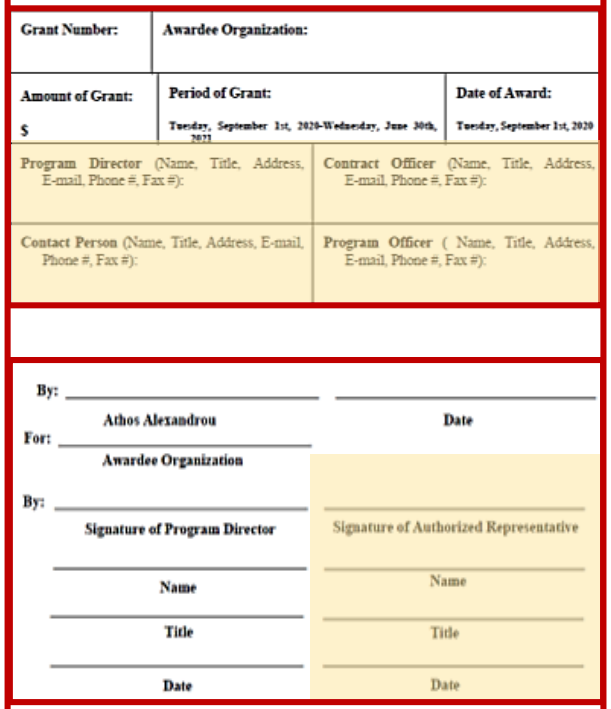

Grant Number:	Awardee Organization:	
Amount of Grant: $	Period of Grant: Tuesday, September 1st, 2020-Wednesday, June 30th, 2021	Date of Award: Tuesday, September 1st, 2020
Program Director (Name, Title, Address, E-mail, Phone #, Fax #):		Contract Officer (Name, Title, Address, E-mail, Phone #, Fax #):
Contact Person (Name, Title, Address, E-mail, Phone #, Fax #):		Program Officer (Name, Title, Address, E-mail, Phone #, Fax #):

By: _____ _____
Athos Alexandrou — Date
For: _____
Awardee Organization

By: _____ _____
Signature of Program Director — Signature of Authorized Representative
Name — Name
Title — Title
Date — Date

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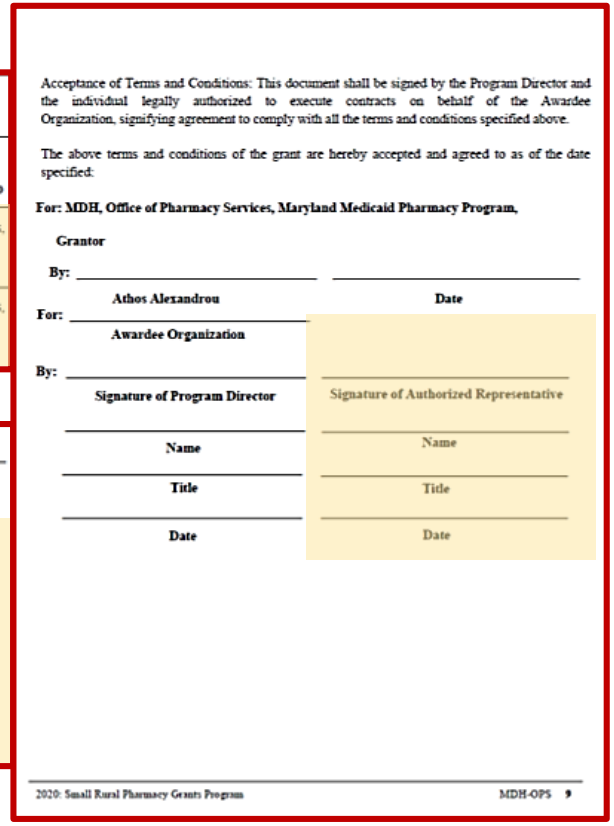

Acceptance of Terms and Conditions: This document shall be signed by the Program Director and the individual legally authorized to execute contracts on behalf of the Awardee Organization, signifying agreement to comply with all the terms and conditions specified above.

The above terms and conditions of the grant are hereby accepted and agreed to as of the date specified:

For: MDH, Office of Pharmacy Services, Maryland Medicaid Pharmacy Program,
Grantor

By: _____ _____
Athos Alexandrou — Date
For: _____
Awardee Organization

By: _____ _____
Signature of Program Director — Signature of Authorized Representative
Name — Name
Title — Title
Date — Date

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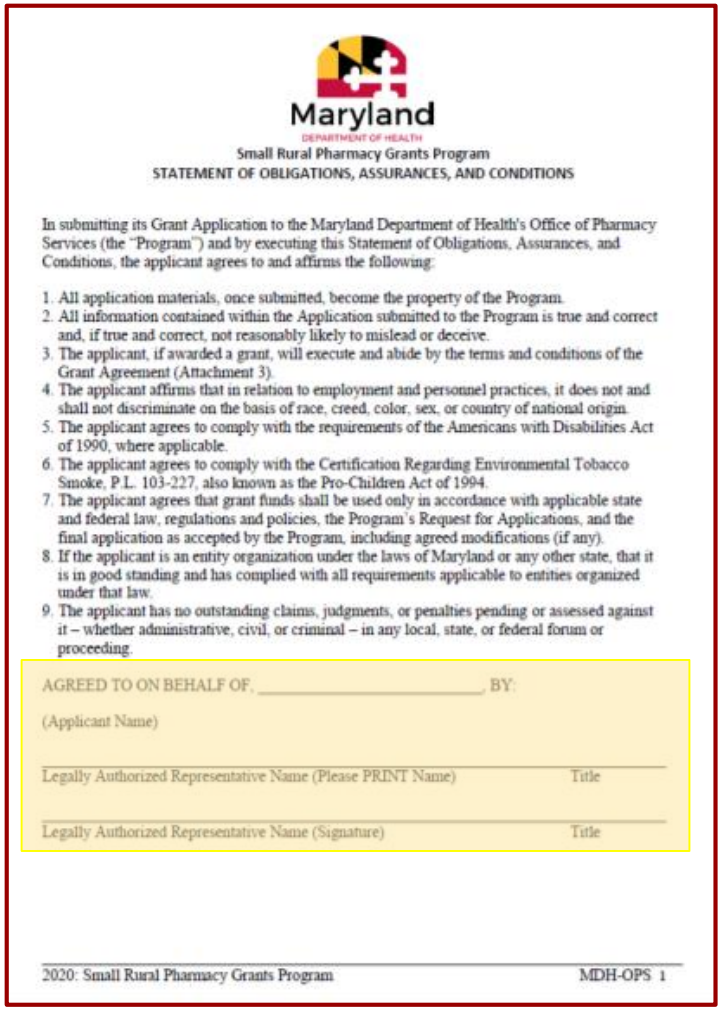
Awards Documents cont. –
Statement of Obligations, Assurances, and Conditions



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Small Rural Pharmacy Grants Program
STATEMENT OF OBLIGATIONS, ASSURANCES, AND CONDITIONS

In submitting its Grant Application to the Maryland Department of Health's Office of Pharmacy Services (the "Program") and by executing this Statement of Obligations, Assurances, and Conditions, the applicant agrees to and affirms the following:

1. All application materials, once submitted, become the property of the Program.
2. All information contained within the Application submitted to the Program is true and correct and, if true and correct, not reasonably likely to mislead or deceive.
3. The applicant, if awarded a grant, will execute and abide by the terms and conditions of the Grant Agreement (Attachment 3).
4. The applicant affirms that in relation to employment and personnel practices, it does not and shall not discriminate on the basis of race, creed, color, sex, or country of national origin.
5. The applicant agrees to comply with the requirements of the Americans with Disabilities Act of 1990, where applicable.
6. The applicant agrees to comply with the Certification Regarding Environmental Tobacco Smoke, P.L. 103-227, also known as the Pro-Children Act of 1994.
7. The applicant agrees that grant funds shall be used only in accordance with applicable state and federal law, regulations and policies, the Program's Request for Applications, and the final application as accepted by the Program, including agreed modifications (if any).
8. If the applicant is an entity organization under the laws of Maryland or any other state, that it is in good standing and has complied with all requirements applicable to entities organized under that law.
9. The applicant has no outstanding claims, judgments, or penalties pending or assessed against it – whether administrative, civil, or criminal – in any local, state, or federal forum or proceeding.

AGREED TO ON BEHALF OF, _____, BY:

(Applicant Name)

_____

Legally Authorized Representative Name (Please PRINT Name) Title

_____

Legally Authorized Representative Name (Signature) Title

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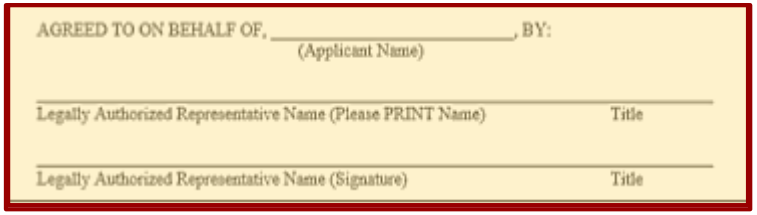

AGREED TO ON BEHALF OF, _____, BY:
(Applicant Name)

_____

Legally Authorized Representative Name (Please PRINT Name) Title

_____

Legally Authorized Representative Name (Signature) Title

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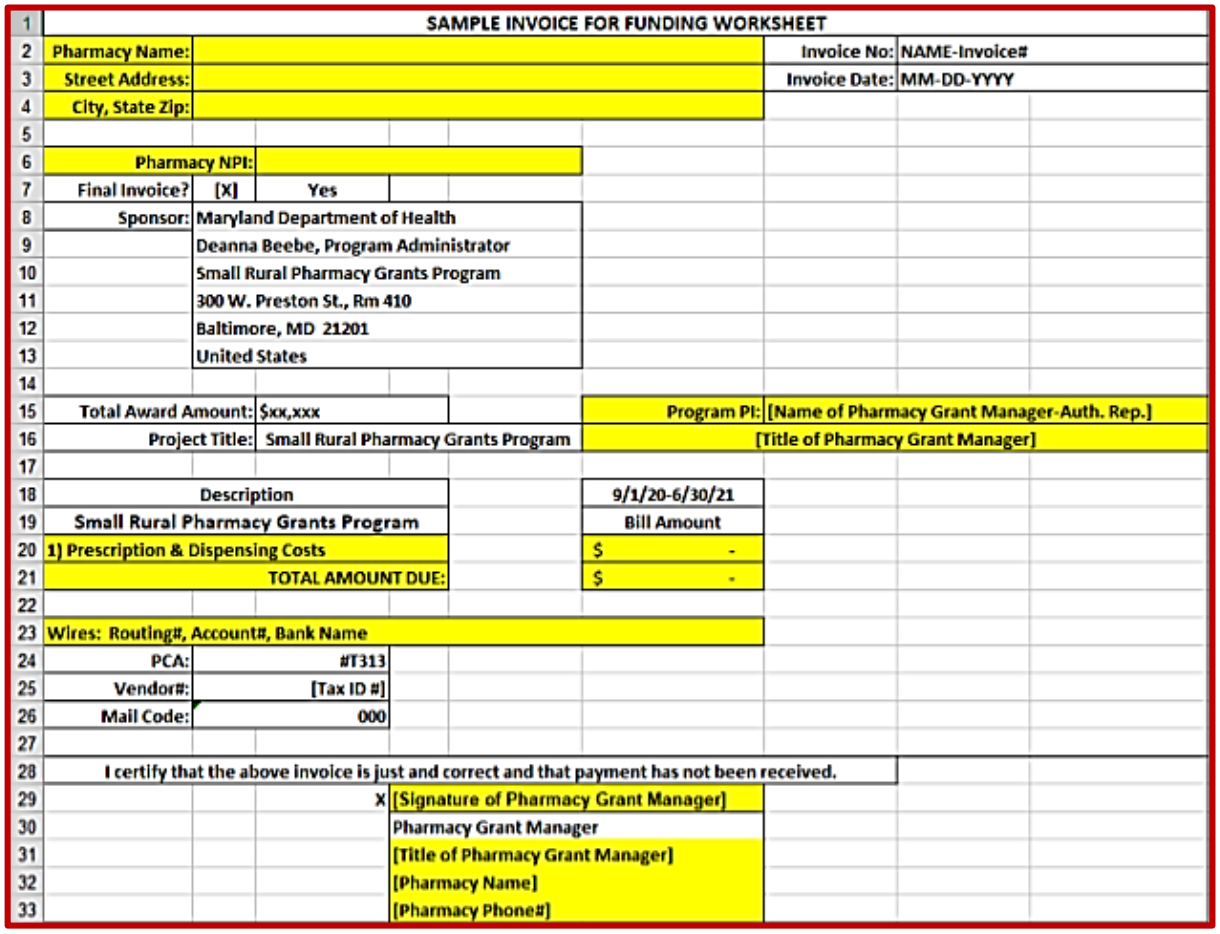
Awards Documents cont. –
Invoice for Funding Worksheet



1	SAMPLE INVOICE FOR FUNDING WORKSHEET				
2	Pharmacy Name:			Invoice No:	NAME-Invoice#
3	Street Address:			Invoice Date:	MM-DD-YYYY
4	City, State Zip:				
5					
6	Pharmacy NPI:				
7	Final Invoice?	[X]	Yes		
8	Sponsor:	Maryland Department of Health			
9		Deanna Beebe, Program Administrator			
10		Small Rural Pharmacy Grants Program			
11		300 W. Preston St., Rm 410			
12		Baltimore, MD 21201			
13		United States			
14					
15	Total Award Amount:	$xx,xxx		Program PI:	[Name of Pharmacy Grant Manager-Auth. Rep.]
16	Project Title:	Small Rural Pharmacy Grants Program			[Title of Pharmacy Grant Manager]
17					
18	Description			9/1/20-6/30/21	
19	Small Rural Pharmacy Grants Program			Bill Amount	
20	1) Prescription & Dispensing Costs			$ -	
21	TOTAL AMOUNT DUE:			$ -	
22					
23	Wires: Routing#, Account#, Bank Name				
24	PCA:	#T313			
25	Vendor#:	[Tax ID #]			
26	Mail Code:	000			
27					
28	I certify that the above invoice is just and correct and that payment has not been received.				
29			X [Signature of Pharmacy Grant Manager]		
30			Pharmacy Grant Manager		
31			[Title of Pharmacy Grant Manager]		
32			[Pharmacy Name]		
33			[Pharmacy Phone#]		

- Lines 2-4: Pharmacy Demographics
- Line 6: Pharmacy NPI
- Lines 15-16: Name of Pharmacy Grant Manager (Auth. Rep. on Grant Agreement)
- Lines 20-21: Total Award Amount for both
- Lines 23: Bank Information
- Lines 29-33: Signature & Manager/Pharmacy Info.

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Timeline

Date	Activity
On or shortly after Friday, July 10th, 2020	Webinar Recording and Slides will be available on the website.
Friday, July 31st, 2020 by 5:00 PM EST	Deadline to submit all application documents.
Friday, August 21st, 2020	Notification of Award Letters emailed/mailed out to Awardees by this date.
Monday, August 31st, 2020 by 5:00 PM EST	Signed Grant Agreement & Statement of Obligations, Assurances, and Conditions and completed Invoice for Funding Worksheet due to the Program.
Tuesday, September 1st, 2020	Beginning of Funding Period. *(*Pending receipt of deliverables and internal processing.)*
Wednesday, June 30th, 2021	End of Funding Period.
Friday, July 30th, 2021 by 5:00 PM EST	Final Report due to Program (no sooner than July 1st, 2021).

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Q&A Session & Contact Information

Athos Alexandrou, Director

Deanna Beebe, Program Administrator

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Q&A Session

- Use the Chat feature to ask questions.
- All questions will be read and answered aloud to all attendees (time permitting).
- A FAQ Document will be created from questions received during the Webinar and posted on the Program website.

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Contact Information

- A downloadable recording of this Webinar session and these slides will be available on the Program's website.

- If you would like the recording and slides emailed directly to you, please email Deanna.

- If you have any further questions about the Small Rural Pharmacy Grants Program, please contact **Deanna Beebe** at deanna.beebe@maryland.gov or **(410) 767-5701** or visit our Program website for more information.

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